Risk management – does it apply to anaesthesia and is it our responsibility?

Risk is defined as the chance of something happening that will impact on one’s ability to achieve one’s objectives. Therefore in anaesthesia risk lies in the quality of patient care (which can lead to disability and death should things go wrong), as well as liability exposure for us as anaesthesiologists.

Risk management comprises all the activities involved in identifying, measuring and controlling this exposure to risk. This in turn allows us to reduce unintentional harm to our patients, many of whom are high-risk anyway, from the medical point of view.

In anaesthesia the additional real or potential risks may include the following:

- Health care funders and “production” pressure, to get through the cases and operation lists, obviously compromising preoperative assessments and not allowing sufficient time to administer a premed to our day cases
- Anaesthesia in remote settings, such as offices, MRI scanners, dental rooms and other areas where patient equipment and monitoring may be sub-optimal. These facilities are required to be “licensed” as a theatre facility, and we have all been subjected to: “This patient needs just a little sedation”……
- Equipment maintenance and the records of this maintenance. This also includes consumables and the provision for avoiding needle-stick injuries. Having said this, it behoves us to remember that equipment failures are rare in comparison with human error.
- Staffing of all operating theatres and recovery room with adequate anaesthetic staff. In addition, in some instances there may be a shortage of doctors
- The lack of policies or guidelines, and where these are available, the lack of adherence to these
- Credentialing, clinical privileging and continuing professional development, ensuring the quality of anaesthesiologists

- Informed consent for anaesthesia, (and blood transfusion where applicable) in keeping with the requirements of the National Health Act
- Record-keeping: this applies to the contemporaneous anaesthetic record, as well as record keeping of accounts

There may well be others, but as can be seen, these are the factors that we are engulfed by, which all may contribute to increasing the risk in administering anaesthesia to our patients.

Quantifying this risk is incredibly difficult. Nevertheless we have certain documents in place that can reduce this risk considerably. The SASA Practice Guidelines (2006) need to be applied to each and every facility where anaesthesia is administered. Many of the potential risks can be reduced in this way – anaesthesia in remote settings, equipment, staffing, record keeping and regional anaesthesia. The SASA Sedation Guidelines meet some of the clinical guidelines requirements. The issue of informed consent has been legislated by our National Health Act 61 of 2003 and is the responsibility of all the doctors involved in treating a particular patient.

Credentialing and clinical privileging is a topic that was raised in South Africa a few years ago by the HPCSA. This appears to be topical at present, as issues relating to nurse anaesthetists in the USA have been the subject of many discussions recently. SASA and the College of Anaesthetists addressed this a few years ago in the form of a “Scope of Practice” Document, which was submitted to the HPCSA. With the new health care worker (the Clinical Associate) on the horizon, perhaps it is time to re-visit who should be administering anaesthesia in South Africa? SASA and the Editorial Board of the SAJAA welcomes your comments on this issue, and on the Scope of Practice document, which is published in this journal.